Medicaid Information Bulletin

July 2002

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Medicaid Information

- **Salt Lake City area, call 538-6155.**
- **In Utah, Idaho, Wyoming, Colorado, New Mexico, Arizona and Nevada, call toll-free 1-800-662-9651.**
- **From other states, call 1-801-538-6155.**

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Send a Publication Request Form.

- **by FAX: 1-801-536-0476**
- **by mail to: Division Of Health Care Financing Box 143106, Salt Lake City UT 84114-3106**

02 - 54 Revised Utah Medicaid Provider Agreement

The Division of Health Care Financing (DHCF) has been working closely with both public and private agencies and organizations to revise the Utah Medicaid Provider Agreement. The revised Provider Agreement dated 3/1/02 was mailed out to providers on March 18. You may continue to operate under the agreement you previously signed. However, we encourage you to sign and return the revised version. If you decide to continue to operate under the prior agreement, you will be afforded all the rights outlined in the new agreement.

Numerical References Corrected

The Provider Agreement mailed March 18, 2002, had two errors in numerical references on pages 4 and 5:

- Page 4, Section II, item 8: The statement beginning "PROVIDERS must not violate paragraph 8, non-discrimination" should be ""PROVIDERS must not violate paragraph 1, non-discrimination."
- Page 5, Section III, item 3: The reference to "paragraph 24 above" should be "paragraph 2 above."

Provider Agreement On-Line

There are now two versions of the Utah Medicaid Provider Agreement on-line: one dated 1/01/01 and the new one dated 3/1/02 (with correct numerical references). There is a link to the agreements on the Medicaid Provider's web site:
www.health.state.ut.us/medicaid/html/provider.html.
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02 - 55 Audiology (Hearing) Not Covered for Non-pregnant Adults

Due to legislative budget reductions in the Medicaid budget, effective for services on or after July 1, 2002, Medicaid will not cover audiology (hearing) services to non-pregnant adults age 21 and older. Children from birth through age 20 and pregnant women continue to be covered.

Audiology Manual Updated

Providers will find pages attached to update their manual. A vertical line in the left margin on pages dated July 2002 indicates where text has changed. ☐

02 - 56 Speech and Language Services Not Covered for Non-pregnant Adults

Due to legislative budget reductions in the Medicaid budget, effective for services on or after July 1, 2002, Medicaid will not cover speech and language services to non-pregnant adults age 21 and older. Children from birth through age 20 continue to be covered under the Child Health Evaluation and Care (CHEC) program. Pregnant women will continue to be covered with the same scope of services as they received prior to July 1, 2002.

Speech-Language Manual Updated

Providers will find pages attached to update their manual. A vertical line in the left margin on pages dated July 2002 indicates where text has changed. An asterisk (*) marks where text was removed and not replaced. ☐

02 - 57 Clarification of Audiology Code Y5500, Diagnostic Audiology Evaluation

Currently, audiologists will continue to use the Y5500 codes for diagnostic audiology evaluation, performed at the request of the physician. This evaluation would include, but is not limited to, a basic comprehensive audiometric exam, i.e.: pure tone, air and bone conduction threshold, speech tests to include speech reception threshold (SRT), speech discrimination score (SD), sound field aided and unaided testing and MCL and UCL values. This code may be used for children through age 20, including age 0 - 1. CPT codes used for audiology evaluations are to be used by physicians only and will not be reimbursed to audiologists. ☐

02 - 58 Copayment Policy Revision

Earlier messages about the copayments for physician, podiatrist, outpatient, and inpatient hospital indicated that copayments and co-insurance were not to be collected for Medicaid recipients who had third party insurance or Medicare. That policy has been reversed, and the Medicaid is now requiring that copayments and co-insurance be collected from clients with third party insurance or Medicare benefits. ☐

02 - 59 Podiatry Not Covered for Non-pregnant Adults

Due to legislative budget reductions in the Medicaid budget, effective for services on or after July 1, 2002, Medicaid will not cover podiatry services to non-pregnant adults age 21 and older. Children from birth through age 20 continue to be covered under the Child Health Evaluation and Care (CHEC) program. Pregnant women will continue to be covered with the same scope of services as they received prior to July 1, 2002.

As a reminder, from November 1, 2001, through June 30, 2002, many adult Medicaid clients were required to make a $2.00 co-payment for office visits performed by a podiatrist. Because services may be billed to Medicaid up to one year after the date of service, Chapter 1 - 3, Co-payment Requirement, will remain in SECTION 2 of the Podiatry Manual. It will be removed when the one-year billing deadline expires on June 30, 2003.

Podiatry Manual Updated

Providers will find pages attached to update their manual. A vertical line in the left margin on pages dated July 2002 indicates where text has changed. ☐

02 - 60 Medicaid Provider Training

Statewide provider training is tentatively scheduled for August through October 2002. Sessions include policy updates, new programs, billing issues, etc. Office appointments for training sessions can also be scheduled on a first come, first serve basis, coordinating with the statewide provider training locations. If you have a particular topic you would like discussed in the sessions, please contact the Training and Special Projects Unit by FAX at (801) 536-0976. Specific dates and session locations, as well as e-mail address and phone line to request an office appointment, will be announced in a separate mailer and on the Medicaid web site at www.health.state.ut.us/medicaid/training.pdf. ☐

02 - 61 Dental Program Changes:

- **Dental services not covered for non-pregnant adults, except emergencies**
- **Office visit, after hours**

Due to legislative budget reductions in the Medicaid budget, effective June 1, 2002, Medicaid dental services to non-pregnant adults age 21 and older are limited to emergencies only. Services include an emergency exam, emergency X-ray, and an emergency extraction provided by a dentist for relief of pain and infection for adults. Covered codes are:

- D0140, Limited oral evaluation, problem focused
- D0220, Intraoral - periapical - first film
- D7110, Extraction, single tooth
- D7210, Surgical removal of erupted tooth . . .

Office Visit, After Hours

A definition of “Office visit, after regularly scheduled hours” (code D9440), is added To SECTION 2, Dental Care Services, as a new Chapter 1 - 20.

Manuals Updated: Dental and Oral Maxillofacial Surgeon Services

- SECTION 2 of the Utah Medicaid Provider Manual for Dental Care Services is updated to include the July 2002 changes. Dentists will find attached a revised SECTION 2 to update their manual. Please keep the ADA form instructions.

- To clarify the Provider Manual for Oral Maxillofacial Surgeon Services, Dental Care Services is added to the oral surgeon’s manual as a new SECTION 3. SECTION 2, Oral Maxillofacial Surgeon Services, now contains information which applies only to oral surgeons. It no longer repeats information contained in the section for Dental Services. Oral surgeons will find the following updates attached:
  - SECTION 2, Oral Maxillofacial Surgeon Services;
  - SECTION 3, Dental Care Services; and
  - ADA form instructions

A vertical line in the left margin of a page indicates where text was changed. An asterisk (*) marks where text was removed and not replaced. ☐

02 - 62 Medicaid Fraud Control Unit, Name and Address Correction

The Medicaid Fraud Control Unit (MFCU), formerly the Medicaid Fraud Unit, has relocated. The agency name, address and telephone numbers are corrected in SECTION 1 of the Utah Medicaid Provider Manual, Chapter 6 - 17, Medicaid Audits and Investigations, item V, Complaints and Appeals (page 28C).

Send complaints regarding the MFCU to:
Office of the Attorney General
Medicaid Fraud Control Unit
5272 South College Drive, Suite 200
Murray, Utah 84123

For complaints about investigations and personnel misconduct, send to the attention of: Director, Division of Criminal Investigations and Technical Services.
Or call (801) 284-6200

For complaints about MFCU procedures, send to the attention of:
MFCU Director
Division of Investigations
Office of the Attorney General
Medicaid Fraud Control Unit
5272 South College Drive, Suite 200
Murray, Utah 84123

Or call (801) 284-6218 or (801) 826-2215 ☐

02 - 63 Corrections: Client Notice for Medicaid Program Reductions

A notice about the Medicaid program cuts was sent to clients with the May Medicaid cards. The notice had two errors. It should have stated that the new program limitations were for **non-pregnant** adults age 21 and older. Children age 20 and younger, **and pregnant women**, continue to be covered. This coverage is made clear in the articles in this bulletin about audiology, speech-language, podiatry, and dental services.

Also, the telephone number on the notice is incorrect. The telephone numbers for Medicaid Customer Service are the same as the numbers for Medicaid Information. Salt Lake area: (801) 538-6155. Toll-free: 1-800-662-9651. Hours are Monday through Friday from 8 a.m. to 5 p.m. ☐

ON THE INTERNET: Utah Medicaid Provider Manuals, Bulletins, Forms, Notices

Each month more Medicaid manuals, forms, notices and other printed materials are published on the Internet. Each document, or category of documents such as "manuals", has a link on the Utah Medicaid Provider's web site: www.health.state.ut.us/medicaid/html/provider.html. There is also a link to the Medicaid fee schedule and an index to Medicaid Information Bulletins.

Medicaid manuals are available using links on a SECTION 2 list. Find the SECTION 2 list using a link on the Medicaid Provider's web site. The list has the names of all Medicaid manuals and special attachments, but only a few of these are on-line. Read the instructions at the top of the SECTION 2 list.

At this time, five provider manuals and a number of special attachments are available on the Internet. We suggest that, when you find a document or manual you want to look at again, you set a "bookmark". For example, set a bookmark for the Physician Services Manual at www.health.state.ut.us/medicaid/phystoc.pdf.

Printed, paper copies

You may also request a paper copy to be mailed to you. Call Medicaid Information or send in a Publication Request Form. A copy of this form is in the General Attachments Section of the Utah Medicaid Provider Manual.

02 - 64 Medical Supplies: Age Limits on Bathroom Equipment

Two items on the Medical Supplies List in the category Bathroom Equipment (page 21) have age limits. The limits are added to the list.

– Age limit on code Y6046, Position support bath system, is 6 to 20 years.

– Age limit on code Y6079, Toilet Seat, Support/reducer ring, is 0 to 20 years.

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02 - 65 Physician Assistant Services

Based on recent policy review and on a change in the Utah Practice Act for Physician Assistants, the service which can be provided by a physician assistant has been more clearly defined.

On November 15, 2001, amendments to the Physician Assistant Practice Act rules became effective. The working relationship between physician and physician assistant remains the same. The changes allow the physician and physician assistant to determine the appropriate amount of supervision and how that supervision will be documented. Under the rules, the following applies:

- The supervising physician shall provide supervision to the physician assistant to adequately serve the health care needs of the practice population and ensure that the patient's health, safety and welfare will not be adversely compromised.
- A Delegation of Services Agreement, maintained at the site of practice, shall outline specific parameters for review that are appropriate for the working relationship.
- There shall be a method of immediate consultation by electronic means whenever the supervising physician is not present and immediately available.
- The supervising physician shall review and co-sign sufficient numbers of patient charts and medical records to ensure that the patient's health, safety, and welfare are not adversely compromised.

A physician assistant can provide services consistent with the practice of the physician with whom he works. If the physician is a primary care provider, then by definition the physician assistant working with that physician would be providing primary care services. Under the statute, the physician assistant works under the supervision of a physician, is not an independent practitioner, and cannot bill independently. Physician assistant services are limited to outpatient, ambulatory, office type services in the office of the physician. No hospital or other facility type services are authorized.

Physician Assistant Services

The Utah Medicaid Provider Manual for Physician Services is updated to include the clarification on physician assistant services. Providers will find attached the pages needed to update their manuals. A vertical line on pages dated July 2002 indicates where text has changed.

Physician Manual On-line

There is a link to the SECTION 2 list of manuals by provider type, including physician, on the Medicaid Provider's web site: www.health.state.ut.us/medicaid/html/provider.html. ☐

02 - 66 Private Room Payment Requirements

Conditions for coverage for a private room have been added to both the Hospital and Physician Services Medicaid Manuals, under Chapter 3, LIMITATIONS. Briefly, a private room is covered when clinically indicated to prevent the spread of an infectious disease and in cases where the patient is colonized with a multi-drug-resistant organism which may present a serious risk of spread to other patients.

Coverage will be based on current Centers for Disease Control and Prevention (CDC) guidelines. For the guidelines, refer to the Provider Manual. Revised pages to update the manuals are attached. On pages dated July 2002, a vertical line indicates where text was added. ☐

02 - 67 Botulinum Toxin (Botox), Coverage Requirements

Medicaid will cover Botulinum Toxin Type A (Botox) treatment with documentation of medical necessity. Coverage requirements for code J0585, Botulinum toxin Type A, have been added to the Injectable Medications List which is included with the Utah Medicaid Provider Manual for Physician Services. Providers will find attached a new page 17 - 18 to update the list. A vertical line on the page indicates where text was added.

Injectable Medications List On-line

There is a link to the SECTION 2 list of manuals by provider type, including the physician manual and its special attachments, on the Medicaid Provider's web site: www.health.state.ut.us/medicaid/html/provider.html. ☐

02 - 68 Drug Criteria and Limits: Changes and Additions:

- **Low molecular heparins (LMWH)**
- **Lactulose, Miralax**
- **Kineret; Enbrel**
- **Epoetin alfa, darbepoetin alfa**
- **Tryptans**
- **Modafinil (Provigil)**
- **Proton Pump Inhibitors**
- **Ritalin / Methylphenidate**

Criteria for coverage of the drugs listed above been modified on, or added to, the Drug Criteria and Limits List. This list is included with the Utah Medicaid Provider Manual for Physician Services and for Pharmacy Services. A brief summary of coverage is stated below. Changes are effective July 1, 2002, unless noted otherwise. For complete information, refer to the July 2002 Drug Criteria and Limits List. Providers will find attached the pages needed to update the list. A vertical line on pages dated July 2002 indicates where text has changed or been added.

Drug List On-line

There is a link to the SECTION 2 list of manuals by provider type on the Medicaid Provider's web site: www.health.state.ut.us/medicaid/html/provider.html. On the SECTION 2 list, there is a link to the Drug Criteria and Limits list for both the physician and pharmacy manuals.

Summary of Drug Changes and Additions

1. The prior approval criteria for the low molecular heparins (LMWH) have been modified to provide for a two-day pre-op coverage for clients on Coumadin **and** a five-day post-op coverage while a stable Coumadin pro-time is established.

2. Lactulose syrup prior approval criteria have been modified to allow up to 1800 ml per 30 day period without a prior approval. Amounts above that still require prior approval. Miralax access has been restricted to allow 1054gms per 30 day period without a prior approval. Amounts above that will require a prior approval. The standard dose of Miralax is 17 gm per day.

3. Kineret, the new recombinant, nonglycosylated form of the human interleukin-1 receptor antagonists (IL-1Ra) is available on prior approval for rheumatoid arthritis. The criteria for Enbrel, also available on prior approval for rheumatoid arthritis has been made less restrictive.

4. Epoetin alfa and darbepoetin alfa have been placed on prior approval and are covered for:
   EPOETIN ALFA, DARBEPOETIN ALFA:
   A. anemia associated with renal failure if patient is not on dialysis
   B. anemia associated with chemotherapy for non-myeloid malignancies where clients will be receiving chemotherapy for a minimum of two months.

   EPOETIN ALFA ONLY
   A. blood transfusions, allogenic and anemic surgery patients (approve one time only)
   B. anemia associated with treatment with Zodovudine in HIV infection

   These agents are not available through the pharmacy program for clients receiving hemodialysis. Bill using CPT code 90937 for hemodialysis with epoetin alfa included. Bill using CPT code 90935 for hemodialysis without eopoetin alfa.

5. The DUR Board has reduced the "tryptan" cumulative number of doses available from 18 to 9 doses with an option of getting more through a prior approval. "Migrainers" should be using one prophylactic medication and have failed on three others, or have contraindications against the prophylactic medications. Physicians should be encouraged to use metoclopramide to ensure that the migraine medications are being absorbed unless contraindicated. The metoclopramide also reduces nausea and vomiting which is often associated with migraine. The DUR Board recommended treating no more than twice a week to prevent re-bound headache.

6. Modafinil (Provigil) has been placed on telephone prior approval. The covered labeled and off label indications are described on page 40 of the Drug Criteria List.

7. Criteria for proton pump inhibitors is revised. B.i.d. dosing requires a prior approval for the first 60 days and a petition to the DUR Board for longer periods.

8. Ritalin / Methylphenidate for ages 19 and older diagnosed with ADD: Contraindications no longer include schizophrenia and schizo-affective disorder.

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02 - 69 Epidural and Nerve Blocks (EpiBlock Management)

Conditions for coverage for epidural and nerve blocks (EpiBlock management) have been added to the Criteria for Surgical Procedures list, an attachment to the Utah Medicaid Provider Manual for Physician Services and for Hospital Services. Claims related to pain management will be reviewed periodically and are subject to post payment review.

There are three types of injections. Steroids are given to reduce inflammation as treatment for chronic radiculopathy caused by nerve root irritation or pressure (i.e., spinal stenosis) when conservative medical treatments have failed. Anesthetic or narcotic injections are injected into the epidural space to achieve a sympathetic block for the diagnosis and treatment of reflex sympathetic dystrophy and para vertebral blocks are used when the patient has localized pain that is aggravated by motion of the spine without a strong radicular component or associated neurologic deficit. Nerve block and epidural injections are not intended for ongoing or long term pain management.

The criteria for Trigger Point Injections are renumbered on the Criteria for Surgical Procedures list as Criteria #33A. EpiBlock policy is added as Criteria #33B. Providers will find attached the pages needed to update the criteria list. A vertical line on pages dated July 2002 indicates where text has been added.

The Medical and Surgical Procedures "CPT Code List" is updated to include CPT codes related to epidural and nerve blocks. Each code that is added to the list has the statement, "PRIOR APPROVAL: Not Required. Refer to Criteria #33B[2]." The codes added to the CPT list are:

20610, major joint or bursa; sacroiliac joint injection

62310, 62311: Injection DX or RX substance (anesthetic) epidural or subarachnoid . . .

62318, 62319: Injection/cath placement for drug infusion epidural or subarachnoid . . .

64405, 64418, 64420, 64421, 64435, 64470, 64472, 64475, 64476, 64479, 64480, 64483, 64484, 64510, 64520, 64530: anesthetic injection . . .

If you want a new copy of the Medical and Surgical Procedures "CPT Code List" which includes the CPT codes related to epidural and nerve blocks, please contact Medicaid Information. Ask for the July 2002 Medical and Surgical Procedures "CPT Code List" in the Physician's Manual. ☐

02 - 70 Corneal Topography Criteria

Conditions for coverage for corneal topography (corneal topographic mapping) are added to the Criteria for Medical and Surgical Procedures list, an attachment to both the Hospital and Physician Services Medicaid Manuals. Providers will find attached a new page 33-34 with the criteria. Corneal topographic mapping is a diagnostic procedure used to detect corneal surface irregularities and astigmatism. The procedure involves visualization of the corneal surface. Since the procedure does not have a CPT code, it is billed with code 92499, Unlisted ophthalmological service or procedure. According to Medicare, services are similar to code 92286, Special anterior segment photography with interpretation and report; with specular endothelial microscopy and cell count. Therefore, reimbursement established for code 92286 will be used for 92499.

Code 92499 is added to the list Medical and Surgical Procedures "CPT Code List" with a reference to the new Criteria #35: Corneal Topography. If you want a new copy of the list Medical and Surgical Procedures "CPT Code List" with code 92499 added, please contact Medicaid Information. Ask for the July 2002 Medical and Surgical Procedures "CPT Code List" in the Physician's Manual. ☐

02 - 71 Skin Lesions Criteria Clarified

Criteria #34, Removal of Benign or Premalignant Skin Lesions, issued April 2002, has two corrections. See the attached page 31 of the Criteria for Medical and Surgical Procedures list, an attachment to both the Hospital and Physician Services Medicaid Manuals, under the subheading "Limitations."

- Item #4 is a duplicate of item #2 and has been removed. Subsequent items are renumbered.

- Newly renumbered item #5 is corrected as follows:
  "5. Benign lesion excision, codes 11300-11313, 11400 - 11446 and 17000-17110, may be reviewed under this policy. Medical record documentation must support the medical necessity of surgical excision over another removal procedure and support that the removal was not for cosmetic purposes."

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02 - 72 Trigger Point Injection: Criteria Clarified

One additional criterion is added to Criteria #33, Trigger Point Injections, in the Criteria for Surgical Procedures list, an attachment to both the Hospital and the Physician Services manuals. The new criterion is inserted as item number 6, and subsequent items renumbered. The new item 6 is as follows:

"6. Nerve block injection codes 64400-64530, code 20610, and code 10160 will not be paid on the same date of service."

This clarification is needed because code 20610 is being used to bill for trigger points as well as the specific code 20552, Injection; single or multiple trigger point(s), one or two muscle group(s).

Trigger Point Injection Criteria Renumbered

Due to the addition of Criteria #33B, Epidural and Nerve Blocks, the criteria for Trigger Point Injections are renumbered as Criteria #33A on the Criteria for Surgical Procedures list. The reference is changed for code 20552, Injection . . . on the Medical and Surgical Procedures "CPT Code List." For a printed copy of the corrected CPT Code list, contact Medicaid Information. Ask for the July 2002 Medical and Surgical Procedures "CPT Code List" in the Physician's Manual. ☐

02 - 73 CPT Codes: Changes in Coverage and Requirements for Documentation and Prior Approval

As of July 1, 2002, the CPT codes listed below require documentation. Descriptors are abbreviated in this article. The changes are made to the Medical and Surgical Procedures "CPT Code List," an attachment to Utah Medicaid Provider Manual for Physician Services.

Submit documentation for the following codes with the claim form for prepayment review. Documentation should include medical records, such as the operative report, patient history, physical examination report, pathology report, and discharge summary, which provide enough information to identify the procedure performed and to support medical necessity of the procedure. Prior approval is not required.

- 72196, Magnetic resonance . . . imaging, pelvis;. . .
- 87800, Infectious agent detection by nucleic acid . .
- 99354, Prolonged physician service . . . ; First hour
- 99355 . . . . ; Each additional 30 minutes . . .
- 99356, Prolonged physician service . . . ; first hour
- 99357 . . . . ; each additional 30 minutes . . .

Prior Approval Requirement Changed

Code 90805, Individual psychotherapy . . . , is covered for patients through age 18 without prior approval. For patients age 19 and older, written prior approval is required.

Codes Not Covered

The two codes listed below will no longer be covered. They are added to the CPT list as "NOT A BENEFIT".

82962, Glucose . . . monitoring device(s) . . . ,

01953, Anesthesia for second and third degree burn excision or debridement . . . . For this type of service, use code 01952 to bill.

Medical and Surgical Procedures "CPT Code List" Updated

If you want a new copy of the Medical and Surgical Procedures "CPT Code List" with the July corrections, please contact Medicaid Information. Ask for the July 2002 Medical and Surgical Procedures "CPT Code List" in the Physician's Manual. ☐

02 - 74 Evaluation and Management Documentation Guidelines and Medical Record Review

Evaluation and Management documentation guidelines were initially developed jointly by the American Medical Association and the Health Care Financing Administration and implemented in 1995. A revised set of guidelines was issued in 1997 for use beginning in July 1998. Some changes may be considered again, but until such time as changes are officially announced and implemented, the 1997 guidelines are accepted by Utah Medicaid and utilized by staff reviewers during the Utilization Management record review process. Any decisions made by Utah Medicaid staff while completing the required quarterly review of medical records will be based on the 1997 Evaluation and Management Documentation Guidelines issued by the Health Care Financing Administration.

SECTION 1 of the Utah Medicaid Provider Manual, Chapter 10 - 4, Documentation and Signature Requirements, page 38A, is updated to add the information above as a note. There is a link to the July 2002 update of SECTION 1 on the Medicaid Provider's web site:
www.health.state.ut.us/medicaid/html/provider.html. ☐

02 - 75 Health Common Procedure Coding: Anesthesia Changes

Code revisions for anesthesia in the 2002 Health Common Procedure Codes make it necessary to make changes in the Medicaid anesthesia policy for obstetrical anesthesia. New HCPCS codes may be used for dates of service on or after January 1, 2002.

The following codes were discontinued April 1, 2002:

00850, Intraperitoneal procedures in lower abdomen; cesarean section

00857, Neuraxial analgesia/anesthesia labor ending in cesarean section delivery

00955, Neuraxial analgesia/anesthesia labor ending in vaginal delivery.

The discontinued codes are replaced by the following HCPCS codes:

01961, Anesthesia for; cesarean delivery only

01967, Neuraxial labor analgesia/anesthesia for planned vaginal delivery

01968, Cesarean delivery following neuraxial labor analgesia/anesthesia.

These revisions necessitate the following clarification of policy and instructions for billing anesthesia services.

Obstetrical Anesthesia - Time Reporting

The policy for reporting time units for obstetrical anesthesia has not changed. Because obstetrical anesthesia is unique and an anesthesiologist may attend more than one patient concurrently under continuous regional anesthesia, there is a reduction in the unit value after the first hour of anesthesia time. For the first hour, 5 time units will be calculated; for the second hour, 2.5 units; for the third and each succeeding hour of anesthesia, 1.25 units.

For dates of service on or after January 1, 2002, the reduction in unit value applies only to the following ASA procedure code: 01967, Neuraxial Labor Analgesia/Anesthesia For Planned Vaginal Delivery.

Multiple Obstetrical Procedures

New codes were added, effective for dates of service on or after January 1, 2002, to cover multiple procedures. Basic value units will be covered for multiple procedures in the following circumstances:

– Neuraxial Labor Analgesia/Anesthesia For Planned Vaginal Delivery which becomes a Cesarean delivery.
  Code 01967 to begin the procedure. When C-section is imminent, discontinue use of 01967 and change to —
  Code 01968 and continue on with straight time as for a general surgery
– Neuraxial analgesia/anesthesia for planned vaginal delivery followed by tubal ligation on the same day as delivery or the next day.
  Code 01967 for delivery
  Code 00851 (New Code) - Intreperitoneal Lower Abdomen, Tubal Ligation / transection.

Medicaid is aware that there are other combinations that could be performed together.

Obstetrical Pain Management Services

Effective for dates of service on or after January 1, 2002, post-partum pain management by anesthesiologists is not reimbursed on the same day as a C-section delivery. It is considered part of the anesthesia service when an epidural catheter is in place. A bolus dose of a selected pain medication can be administered through the existing catheter before the patient is released to post-operative care, but no extra time or units will be covered.

Codes 62310 and 62311 are not appropriate for this administration and will not be covered in conjunction with obstetrical anesthesia.

If pain management services extend to the day following delivery, coverage will be provided, consistent with the Post Operative Pain Management Policy, through use of the following code: 01996, Daily follow-up and management of epidural analgesia.

Additional Changes

Other coding revisions may affect documentation and reimbursement. For example: 00840, Intraperitoneal Lower Abdomen, including Laparoscopy, is no longer appropriate for a tubal ligation. For dates of service on or after January 1, 2002, use 00851, Intraperitoneal Lower Abdomen, Tubal Ligation/Transection.

Anesthesia Manual Updated and On-Line

Providers will find an updated SECTION 3, Anesthesia Services, for the Utah Medicaid Provider Manual for Physician Services. A vertical line on pages dated July 2002 indicates where text has changed or added.

There is a link to the SECTION 2 list of manuals by provider type on the Medicaid Provider's web site: www.health.state.ut.us/medicaid/html/provider.html. The link to the Anesthesia manual is under "Physician" on the SECTION 2 list. ☐

02 - 76 Child Health Measurements for 2001

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ú Well child visits, 58%: DOWN from Year 2000
ú Dental services, 33%: DOWN from Year 2000

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ü Blood lead level tests, UP from Year 2000
ü Immunizations, 31%: UP from Year 2000

State Medicaid programs are required to report on the percentage of children who receive well-child (CHEC) visits. The report format is known as the CMS-416, formerly known as the HCFA-416.

Well Child (CHEC) Visits

The results reported for federal fiscal year 2001 show a significant decrease in the percentage of children receiving well child (CHEC) visits, a decrease in the number of children receiving preventive dental services and an increase in the number of children who are appropriately tested for blood lead level.

The percentage of children who received well child visits dropped significantly from 87% to 58%. While the percentage of children under age one year who received at least one well-child visit remained stable, the rates for children age three years and older dropped. The federal target level for the overall participation level is 80%.

Dental Services

The numbers of children receiving dental services dropped, but it is most useful to compare the percentages of children receiving services. DHCF has reported to CMS the participation rate for children over age one who receive any dental service. For federal fiscal year 2000 we reported that 33.34% of our children received any dental service. For federal fiscal year 2001 we reported that 32.76% percent of our children received any dental service.

Blood Lead Level Testing

On the bright side, more children received a blood lead level test.

Utah reported the following for federal fiscal year 2001:

Age group	Total	< 1	1 - 2	3 - 5	6 - 9	10 -14	15 - 18	19 - 21
# of children	123,679ú	24,434ü	21,667ú	22,895ú	18,414ú	17,903ú	12,163ú	6,203ú
Participation Ratio	58%ú	86%ú	50%ú	49%ú	44%ú	38%ú	39%ú	17%ú
# of children referred for follow up treatment	24ú	11ü	2ú	3ú	6ú	1ú	1ú	0û
Children who received preventive dental services	8,016	8	503	2371	2375	1981	676	101
Children receiving blood lead level tests	526ü	161ü	285ü	80ü				

- The number of children reflects an unduplicated count of all children enrolled in Medicaid during the reporting period.
- The '*Participation Ratio*' reflects the percent of children who received at least one well-child (CHEC) visit during the time period. Note this does not mean that children received all visits recommended on our periodicity schedule, but that this percent of the children received at least one visit.
- The number of children referred for follow up treatment from one of those well-child (CHEC) visits is very low. We believe that health care providers do refer children for follow up treatment based on what they find during the well-child visit, but are not informing us. Please remember to use the CF modifier with the CPT4 well-child code when submitting claims.
- The number of children who receive preventive dental services is low. We encourage families to take children to the dentist for preventive care twice a year. Please help us by reminding parents of the importance of oral health.
- The number of children who receive blood lead level tests is also very low. Children ages 0 to 72 months should have a verbal assessment of their risk for exposure to lead. Children at high risk and those who are 12 and 24 months should have a blood lead level test.
- The arrows indicate an increase, decrease or no change from last year.

Immunizations

All states now participate in the Centers for Medicare and Medicaid Services (CMS), the federal agency formerly known as HCFA, Government Performance and Results Act (GPRA) Immunization Measure. Utah was one of the original states which agreed to participate. The Immunization Program in the Division of Community and Family Health Maternal and Child Health Bureau has been an active partner in this measure.

We chose to define 'fully immunized' as 4 DtaP, 3 Polio, 1 MMR, 3 Hep B, and 3 Hib. We selected a sample of 400 children who turned two during the base line year and who had been enrolled in Medicaid for at least six continuous months. We looked at records from our MMIS claims system and the Utah Immunization Information System (USIIS). We received more complete data from these sources this year.

The information collected was input to a CASA program. For federal fiscal year 1999, our baseline year, we could identify only 19% of the children in our sample as fully immunized. For federal fiscal year 2000, we identified that 27.75% of all children in our sample were fully immunized. For federal fiscal year 2001 we identified 31.25% of the children in our sample were fully immunized. These rates show progress, but we still have a long way to go.

For more information on either of these child health measures, please contact Julie Olson at 801-538-6303 or julie.olson@utah.gov

02 - 77 Neulasta, Coverage of, for Physician Only

Neulasta, a new drug available as a l0mg/ml syringe, may only be billed by a physician. The drug is a colony-stimulating factor administered as a single fixed dose per chemotherapy cycle. It is indicated to decrease the incidence of infection in patients with nonmyoloid malignancies receiving myolosuppressive anti-cancer drugs. Physicians, bill Medicaid using code J3490. The drug is added to the Injectable Medications list which is included with the Utah Medicaid Provider Manual for Physician Services.

Injectable Medications List On-line

There is a link to the SECTION 2 list of manuals by provider type, including the physician manual and its special attachments, on the Medicaid Provider's web site: www.health.state.ut.us/medicaid/html/provider.html. ☐

02 - 78 CHEC Manual Changes

The Utah Medicaid Provider Manual for CHEC Services was updated in October 2001 to bring the periodicity schedule for adolescent well child visits in line with American Academy of Pediatrics recommendations. The CHEC Manual is updated effective July 2002 to bring hearing screening recommendations up to date and to recommend use of the 2000 CDC growth charts. Other changes are:

1. Appendix A, Parental Questionnaire for Screening Hearing, has been deleted.
2. A statement is added that expanded services are not available to 19 through 20 year-olds enrolled in the Non-traditional Medicaid program. For information about this new program, refer to bulletin 02 - 83, New Medicaid Programs: Non-Traditional Medicaid Plan and Primary Care Plan.

CHEC Manual On-line

On the Medicaid Provider's web site www.health.state.ut.us/medicaid/html/provider.html, use the link to the SECTION 2 list of manuals. On the SECTION 2 list, there is a link to the CHEC manual. On pages dated July 2002, a vertical line indicates where text has changed. An asterisk on page 6 marks where text was deleted and not replaced. ☐

02- 79 Home Health Services for Pregnant Women

Women who are pregnant, have applied for Medicaid, and have been established with Presumptive Eligibility are eligible for pregnancy-related medical services while they are waiting for their application to be processed. These women will have a "pink card" with an identification number that ends in "V". Occasionally, services which require prior authorization become necessary.

Home health services for IV therapy in the early trimester is a frequent need. When this need arises, the home health agency selected to provide the service must contact the Medicaid Prior Authorization Unit for a prior authorization number. The necessary orders and plan of care must be submitted as required for any home health request for any client. ☐

02 - 80 Client Information and Education

The newsletter "Clientell" is mailed quarterly to clients who receive a Medicaid card. The purpose is to educate and inform clients of Medicaid policies, procedures and other issues. It is also a way to share community resources.

The "Clientell" is published on the Internet. Find the link to client notices and newsletters on the Medicaid Client's web site:
www.health.state.ut.us/medicaid/html/clients.htm .
Copies may be printed and freely distributed for nonprofit, educational purposes. For more information about the publication, see the subsection below.

Articles in the May 2002 issue of the "Clientell":

- Medicaid Changes: Once A Year Fee for Hospital Stays
- Overnight Travel Expenses
- Adults - Helping Services You Quit Smoking
- Medicaid Blood Testing - Lead
- Medicaid Office Move
- Free Summer Lunches for Kids
- Resources and Phone Numbers

Medicaid Client Newsletter "Clientell"

The goals of the "Clientell," published by the Division of Health Care Financing, are to make information easily understood by the Utah Medicaid population and to be sensitive to literacy barriers and cultural differences in this very diverse group of people.

We welcome suggestions for articles from providers and other interested parties. The editor of the "Clientell" is Randa Pickle, Consumer Advocate for the Division of Health Care Financing. Please call 1-877-291-5583 or e-mail suggestions to rpickle@utah.gov. ☐

02 - 81 Rural Health Clinic Manual: Clarifications

Some minor changes have been made to SECTION 2 of the Utah Medicaid Provider Manual for Rural Health Clinic Services. The changes clarify definitions and service coverage. SECTION 2 is attached. See also Bulletin 02 - 82, Prospective Payment System . . . . A vertical line in the left margin on pages dated July 2002 indicates where text has been changed. ☐

02 - 82 Prospective Payment System for Federally Qualified Health Centers and Rural Health Clinics

The Utah Department of Health, Division of Health Care Financing, (hereafter referred to as "the Department") will implement, effective January 1, 2001, the Prospective Payment System (PPS) for Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) as described at Section 1902(a) of the Social Security Act, as amended by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000, (H.R. 5661 as incorporated into the Consolidated Appropriations Act, 2001), (PubLNo106-554).

The base encounter rate will be an average of each FQHC's and RHC's fiscal year costs for years 1999 and 2000, adjusted by the Medicare Economic Index (MEI) for each respective year, divided by the total encounters for those same years. The encounter rate will be a blended rate of all service costs (e.g., medical, dental, etc.), exclusive of costs or encounters for carve-out services. Adjustments to the encounter rate will be made in subsequent years by the application of the MEI and any changes in scope as described below.

FQHCs and RHCs will submit annually to the Department their Medicare Cost Report, trial balances, annual independent audit, and other supplementary information as requested and mutually agreed upon, in order to substantiate the fiscal integrity of each FQHC and RHC as a Medicaid contractor.

The Department will provide to each FQHC and RHC on an annual basis notification of the adjusted PPS reimbursement rate and HMO/carve-out encounter and payment data. Additionally, the Department will document the FQHC and RHC Prospective Payment System within the Medicaid Provider Manual, including subsequent amendments.

Scope of Service Changes

FQHCs and RHCs may request, no more than once per quarter, that PPS payment rates be adjusted for any increases or decreases in the scope of service. A change in the scope of service in an FQHC or RHC can reflect the addition or deletion of an FQHC or RHC - covered service or a change in the intensity, duration, amount and/or character of currently offered FQHC services. The Department will review, prior to approval, all requests to ensure compliance to the Medicare FQHC regulations relative to these changes. The review may take place up to one year after the Department allows the change on an interim basis.

Providers must submit the FQHC and RHC Application for PPS Change in Scope which substantiates the changes and the increase/decrease in costs related to these changes, following Medicare principles of reasonable cost reimbursement. The changes must be significant, with substantial increases/decreases in costs, and documentation must include data to support the calculation of an adjustment to the PPS rate. The cost impact must be material and significant: greater than1% of the FQHCs or RHC's per encounter costs.

Scope Change Adjustment Process

1. FQHCs and RHCs, at their initiation, will notify the Department in writing within 90 days of the effective date of any changes in scope of service and explain the reasons for the change. Any adjustment in encounter rate will be effective for services performed after the date of the change in the scope of services.
2. FQHCs and RHCs will submit the FQHC and RHC Application for PPS Change in Scope which substantiates the changes and the increase/decrease in costs, following Medicare principles of reasonable cost reimbursement, related to these changes.
3. FQHCs and RHCs will be notified in writing by the Department within 30 days of any adjustment to the rate following a review of the submitted FQHC Application for PPS Change in Scope.
4. FQHCs and RHCs may appeal the Department's determination for an adjustment or the amount of the adjustment in accordance with the procedural requirements contained in the Medicaid Provider Manual.
5. For changes in scope that occurred in an FQHC's and RHC's fiscal years 2001 and until PPS implementation in 2002, the above described process will apply.
6. The Department reserves the right to adjust the encounter rate for any scope of change that comes to its attention.

Claims Process

Effective April 1, 2002, for RHCs and May 1, 2002 for FQHCs, all medical claims will be submitted on Form HCFA 1500 [CMS 1500] using the encounter code "T1015". Until further notice, claims for dental services will continue to be submitted on the ADA Dental claim form as currently done. PPS will not be effective for dental claims until the Department can perform additional system programming to accommodate the ADA dental form.

HMO Reimbursements

FQHCs are entitiled to, and must be awarded as requested, contracts with HMOs and carve-out service providers. The FQHC will track billings and reimbursements from vendors in order to document the level of wrap-around payment due from the Department to reconcile to the PPS rate. The Department will make quarterly calculation and payment of HMO/carve-out reconciliation.

Rate Determination for New FQHCs and RHCs

Newly qualified FQHCs after fiscal year 2000 will have initial payments established either by reference to payments to other clinics in the same or adjacent areas, or in the absence of other clinics, through cost reporting methods. This initial payment will be considered an approximation of the provider's cost and will be adjusted after the first full twelve month cost report is submitted. This first period of operation therefore will be paid based upon an allowable cost basis. Once the first full year cost report has been received and reviewed the PPS rate effective for the provider will be the basis of all future payments. New FQHCs and RHCs lacking actual fiscal reports due to no or limited service delivery will submit the FQHC and RHC Application for PPS Change in Scope. The Department will recognize the capital and other start-up costs documented on the schedule in determining the initial PPS rate. Startup costs will be amortized over an estimated useful life not to be less than five years. Actual costs incurred will be reported at the end of the first year of operation and will form the basis for the calculation of the subsequent PPS rate.

After the initial year, the provider's payment rates shall be adjusted to reflect the change in the MEI.

Provider Manuals Updated

Rural Health Clinics will find attached a revised SECTION 2 which includes a new Chapter 4, Prospective Payment System. A vertical line in the left margin on pages dated July 2002 indicates where text has been added. [See also Bulletin 02 - 81, Rural Health Clinic Manual: Clarifications.]

The Utah Medicaid Provider Manual for Physician Services is updated to add Chapter 1 - 6, Prospective Payment System for Federally Qualified Health Centers, to page 4B and the attachment, Prospective Payment System for Federally Qualified Health Centers and Rural Health Clinics.

Physician Manual and PPS Policy On-line

There is a link to the SECTION 2 list of manuals by provider type on the Medicaid Provider's web site: www.health.state.ut.us/medicaid/html/provider.html. The physician manual and the Prospective Payment System Policy have links on the SECTION 2 list. ☐

02 - 83 New Medical Assistance Programs: Non-Traditional Medicaid Plan and Primary Care Plan

Two new medical assistance programs will be available July 1, 2002. These programs are authorized by a waiver of federal Medicaid requirements approved by the federal Center for Medicare and Medicaid Services. Following is a brief summary of eligibility and coverage. Electronic copies of the new policy manuals will be available on the Medicaid Provider's web site www.health.state.ut.us/medicaid/html/provider.html.

NON-TRADITIONAL MEDICAID PLAN

The Non-Traditional Medicaid Plan (NTMP) serves a select group of adults over age 19 and provides a scope of service similar to that currently covered by the Medicaid State Plan, but with some additional limitations and reduced benefits. Providers enrolled with Medicaid for services covered by the Non-Traditional Medicaid Plan will find a new section attached to add to the Utah Medicaid Provider Manual. We suggest adding the new section after provider-specific information (SECTION 2 and special attachments), just before the Table of Contents for the GENERAL INFORMATION Section.

Eligibility

Clients eligible for the Non-Traditional Medicaid Plan are adults over the age of 19, with children, who receive cash assistance from the Utah Family Employment Program (FEP), or they are transitioning into the workforce and eligible to receive medical assistance during the transition, or they qualify as medically needy. The eligibility card for the Non-Traditional Medicaid Plan will be blue.

Services Covered

In general, the Non-Traditional Medicaid Plan covers:

- Inpatient, outpatient, and emergency department services in an acute care general hospital.
- Inpatient medical detoxification for alcohol or drug abuse consistent with Medicaid policy.
- Physician services.
- General preventive services and health education assumed as part of regular office visits, except for Diabetes Self management classes.
- Family planning services consistent with current Medicaid policy.
- Laboratory and radiology services consistent with current Medicaid services.
- Pharmacy, prescriptions with limitations for this plan.
- Dental services, limited to relief of pain and infection.
- Vision services, limited for this plan.
- Mental health services with some limitations.
- Substance abuse services, with limitations.
- Physical therapy, occupational therapy, chiropractic services with limitations.
- End State Renal Disease - dialysis consistent with current Medicaid policy.
- Home health services consistent with current Medicaid services.
- Hospice Services consistent with current Medicaid services,
- Medical supplies and equipment consistent with current Medicaid services.
- Sterilization and/or abortion based on medical necessity and federal and state regulations. Consistent with current Medicaid policy.
- Organ transplants, with limitations.
- Transportation services, limited to ambulance for medical emergencies only. Non-emergency transportation of any kind is not covered.
- Outside medical services in free standing surgical center, emergency center (InstaCare type), or birthing center if chosen by the Plan administrators.
- Targeted Case Management for the homeless, consistent with current Medicaid policy.
- Targeted Case Management for HIV/AIDs, consistent with current Medicaid policy.
- Interpretive services, provided by entities under contract to Medicaid.

Co-Payment and Co-insurance

Co-payment and co-insurance apply to all clients covered in the Non-Traditional Medicaid Plan. The co-payment should be collected even if the client has other third party coverage, including Medicare. Medicaid will automatically reduce the payments for each of these services by the indicated co-payment or co-insurance amounts at the time of reimbursement.

Hospital inpatient services have a $220 co-insurance for each inpatient admission.

Non-emergency use of the emergency room have a $6 co-payment for each visit.

Outpatient hospital services do not have a co-payment.

Physician and physician related services have a $3 co-payment per visit, excluding preventive and immunization services.

Laboratory and Radiology services do not have a co-payment.

Physical therapy, occupational therapy, and chiropractic services have a $3 co-payment.

Prescription drugs have a co-payment of $2 per prescription, no monthly dollar limitation.

Vision Services have a maximum annual benefit of $30. All charges over the annual benefit of $30 will be the responsibility of the patient.

The **maximum out-of-pocket** cost for all co-payment and co-insurance payments is $500 per calendar year.

PRIMARY CARE PLAN

The **Primary Care Plan** serves a population of adults not previously eligible for Medicaid. The Scope of Service is limited to basic medical service of a general nature to provide preventive and palliative care in an outpatient, office setting. Providers enrolled with Medicaid for services covered by the Primary Care Plan will find attached a copy of the Utah Provider Manual for the Primary Care Plan.

Eligibility

Those eligible for the Primary Care Plan are individuals age 19 and above with incomes under 150% of the federal poverty level who are not otherwise eligible for Medicaid through the State Plan and who are eligible only through the Demonstration Waiver. The eligibility card for the Primary Care Plan will be yellow.

Services

In general, the Primary Care Plan covers:

- Hospital services limited only to emergency services provided in an acute care, general hospital emergency department.
- Physician services consistent with current Medicaid policy, but limited only to service that can be provided in the physician's office.
- General preventive services and health education provided by the physician or his supervised staff during regular office visits.
- Family planning services with limitations.
- Laboratory and radiology services only as part of the primary care services in the physician office, by his staff, under his supervision.
- Pharmacy, prescriptions with limitations.
- Dental services to include examinations, x-rays, cleaning, and fillings.
- Vision services, with limitations.
- Medical supplies and equipment, with limitations.
- Transportation services, limited only to ambulance for medical emergencies. Non-emergency transportation of any kind is not covered.
- Interpretive Services consistent with Medicaid.

Co-payment and Co-insurance

Co-payment and co-insurance apply to all clients covered by the Primary Care Plan. Medicaid will automatically reduce the payments for each of the covered services by the indicated co-payment or co-insurance amounts at the time of reimbursement.

Emergency room has a $30 co-payment per visit.

Physician and physician related services have a $5 co-payment per visit. No co-payment for preventive and immunization services.

Laboratory services have a co-payment of 5% of allowed amount if the charges are over $50, and no charge if the allowed amount is $49 or less.

X-ray services have a co-payment of 5% of allowed amount if the charges are over $100, and no co-payment if the allowed amount is $99 or less.

Dental Services have a co-payment of 10% of allowed amount.

Vision Services have a co-payment of $5 per visit.

Prescription drugs have a co-payment of $5 for generic and brand name drugs on Preferred Drug List and 25% for drugs not on Preferred Drug List.

Durable Medical Equipment (DME) has a 10% co-insurance of the allowed amount for designated DME.

The **maximum out-of-pocket** cost for all co-payment and co-insurance payments is $1,000 per calendar year.

SECTION 1: Information on New Medical Plans

Descriptions of the two new medical plans are added to SECTION 1 of the Utah Medicaid Provider Manual, under Chapter 13, OTHER MEDICAL ASSISTANCE PROGRAMS. Chapters 13 - 9, Non-Traditional Medicaid Plan, and 13 - 10, Primary Care Plan, briefly describe who might qualify for the programs, verifying eligibility, covered services, and where to get more information. These chapters are on two new pages 51C and 51D.

SECTION 1 is on-line. There is a link to the current SECTION 1 on the Medicaid Provider's web site: www.health.state.ut.us/medicaid/html/provider.html. ☐

02 - 84 Mental Health Services, Limitations for:

- **Mental Health Centers;**
- **Targeted Case Management for the Chronically Mentally Ill**
- **Substance Abuse Treatment**
- **Substance Abuse Targeted Case Management**

The Medicaid Provider Manuals for Mental Health Centers, Targeted Case Management for the Chronically Mentally Ill, Substance Abuse Treatment and Substance Abuse Targeted Case Management have been updated to reflect service limitations and exclusions effective July 1, 2002. These policy changes are due to implementation of the Utah Primary Care Network Section 1115 Demonstration Program. Under this program, certain Medicaid eligible individuals have a reduced mental health benefit package. Also, certain service exclusions apply to mental health and substance abuse services for these individuals. Also, please note that policy for skills development services has been revised slightly. See the revision under the Skills Development Services section of SECTION 2, Scope of Services.

Manuals Updated

Providers will find attached the pages needed to update their manuals. A vertical line on pages dated July 2002 indicates where text has changed.

- Mental Health Centers: SECTION 2, pages 1 through 20 replaced. The manual is on-line. On the Medicaid Provider's web site www.health.state.ut.us/medicaid/html/provider.html, use the link to the SECTION 2 list of manuals by provider type. There is a link to the Mental Health Centers Manual on the SECTION 2 list.

- Targeted Case Management for the Chronically Mentally Ill: SECTION 2: pages 1 through 7, and page 14 replaced.

- Substance Abuse Services and Targeted Case Management for Substance Abuse Services: SECTION 2, pages 1 through 26 replaced.

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02 - 85 Laboratory Services: CLIA Requirements

The 2002 CLIA list in the Utah Medicaid Provider Manuals for Physician Services and for Laboratory Services is updated to add the covered codes in the list below. The CLIA List is on-line. On the Medicaid Provider's web site www.health.state.ut.us/medicaid/html/provider.html, use the link to the SECTION 2 list of manuals. The CLIA List has a link from either the physician or lab manuals.

Certificate of Waiver, codes added:

82010 QW	82055 QW	82570 QW
82679 QW	83001 QW	83002 QW
84460 QW	87077 QW	87449 QW

Certificate of Waiver, code removed:

Code 87899 QW has been removed because it was replaced with a different code.

CLIA Waiver Kits, codes added:

The following codes are added to the list of CLIA Waiver Kits in numerical order, by manufacturer's name.

Code	Manufacturer	Test Name
82055 QW	OraSure Technologies	OraSure Technologies Q.E. D. A-150 Saliva Alcohol Inc.Test
82055 QW	OraSure Technologies	OraSure Technologies Q.E. D. A-350 Saliva Alcohol Inc.Test
82570 QW	Bayer Corp.	Bayer Clinitek 50 Urine chemistry Analyzer - for Microalbumin, creatinine
82570 QW	Bayer Inc.	Bayer Diagnostics/MICROALBUSTIX Reagent Strip
82570 QW	Bayer Diagnostics	Bayer Multistick Pro 10LS Reagent Strips
82570 QW	Bayer Diagnostics	Bayer Multistick Pro 11 Reagent Strips
82570 QW	Bayer Diagnostics	Bayer Multistick Pro 7G Reagent Strips
83001 QW	Genua 1944 Inc.	Genua Menopause Monitor Test
84460 QW	Cholestech Corp	Acholestech LDX Alanine Aminotransferase (ALT) Test
87077 QW	Medical Instruments	Medical Instruments Corporation Pronto Dry H. Corporation phylori

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